DASIS STATE DATA ADVISORY GROUP MEETING

July 17–18, 2001

Salt Lake City, Utah

Summary
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This meeting is the second of a second round of regional meetings being held with State DASIS Representatives. This meeting included representatives from Arizona, Colorado, Louisiana, New Mexico, Oklahoma, Texas, and Utah along with staff from the SAMHSA Office of Applied Studies, Mathematica for Policy Research, and Synectics for Management Decisions.

Opening and Overview
Dr. Donald Goldstone of the Office of Applied Studies (OAS) gave the opening remarks. He emphasized the importance of these face-to-face meetings between OAS staff and the State people who produce the data. The one-and-a-half-day meetings provide a forum for OAS staff to inform the States about current activities and to give States an opportunity to share with OAS and each other their solutions to common problems in data collection and the management of information.

Dr. Goldstone stressed the importance OAS attaches to State feedback from these meetings and the importance previous comments have already played in developing the N-SSATS questionnaire, modifying the I-SATS On-line, and in changing the names of the DASIS datasets. For example, many of the State representatives at last year's Charleston meeting had been recently assigned to DASIS; they found that the old names (Uniform Facility Data Set, National Master Facility Inventory) did not describe what was involved in the project. At the same meeting, there were complaints that representatives were given the DASIS project but not directions on what to do. In response, OAS has changed the names of the datasets and produced a brochure about the project and what is expected of DASIS representatives.

Dr. Goldstone emphasized that the meeting was a chance to exchange ideas and information on issues important to the States and OAS and that although the schedule was full, it was flexible. Topical items added to the agenda were a presentation on the Health Insurance Portability and Accountability Act (HIPPA), a discussion of performance measures being used in SAMHSA, and some recent design changes planned for the Drug Abuse Warning Network (DAWN).

Demonstration of National Directory Facility Locator
Synectics has developed a system that displays the National Directory on the Web, allows users to query the directory for substance abuse providers, and shows provider locations on a map. The Locator has its own Web site address (http://findtreatment.samhsa.gov). It became operational in November 1999. Since then, the hits on the Locator have gone from approximately 600 a week to just under 3,000 a week. Family members, substance abuse programs, individuals seeking treatment, and professionals who do referrals all use the Locator. The listings include only state-approved facilities, and the current information is based on facilities' answers to the 1999 N-SSATS survey. Soon the Locator will be updated with the 2000 information.

Deborah Trunzo of OAS demonstrated the Locator's three search features. Users can do a quick search, a detailed search, or a list search. In the quick search, the user clicks on a State on a map, then enters a starting point (a street address, city, or zip code). The system searches the file for the substance abuse facilities closest to the starting point. It displays the results on a map and also generates a list with all the current directory information. The search area is a radius of 99 miles from the starting point.

Users can also use the detailed search, which allows users to specify several of the directory variables as an aid in focusing the search. An example of a detailed search is: list all the providers in and around Salt Lake City, Utah, that are in a residential setting, have a treatment program for dually-diagnosed clients, and take private insurance.

The third feature allows users to generate a list of facilities for a geopolitical area using search capabilities similar to the detailed search. The list contains all the treatment facilities meeting the criteria for a geographic area. The area of the search can be one or more ZIP codes, cities, States, or the entire United States. Users can also use this feature to search for a facility by name (or part of a name).

States had questions about individuals' access to the Locator and requested information about key words. Synectics recently completed a review of several search engines and could report that, using the key words "drug treatment program," "substance abuse treatment," and "alcohol treatment facilities," the Locator placed first after the featured sites on four of the major search engines.

Demonstration of I-SATS On-line Quick Retrieval

Up to now States have been unable to search I-SATS or to download all the facilities in their States by selected characteristics. This is about to change. Synectics has added a search capability to the I-SATS On-line. Jim DeLozier demonstrated a new capability that will allow a State person to search I-SATS by city, county, or facility name. In addition, facilities can be selected based on status (active, non-active), state approval (approved, not approved), and whether or not they are a TEDS reporter. Results of all the searches can be downloaded to an Excel file or a text file (tab or comma delimited). Access to the system will be limited to people within a State who have a password for the I-SATS On-line system, and they will have access only to facilities in their State.

A great deal of discussion ensued about the discrepancies between the information States know about a facility or are given through the licensing process and the information facilities report to N-SSATS. Utah and Colorado were particularly concerned about this. Dr. Goldstone reiterated the policy that States have complete control over which facilities gets listed in the Directory and the Locator.

States attending the meeting thought the ability to search for facilities and download information would be helpful, particularly information about non-approved places.

The 2000 National Survey of Substance Abuse Treatment Services (N-SSATS)

Geraldine Mooney of Mathematica for Policy Research (MPR) provided handouts showing the response rates for the 2000 N-SSATS. The response rate for the United States for State-approved facilities was approximately 96 percent. The response rates for the States varied between 100 percent and 93 percent. The response rate has improved from 88 percent to 96 percent since MPR has done the survey. The addition of the Locator has helped in raising the response rate.

She distributed tables showing the results of two questions in N-SSATS relating to licensing or certification. The percentage of non-approved facilities claiming that they were approved by an SSA varied from 40 percent to 73 percent. This table and the one reporting various certifications by JCAHO, CARF, and NCQA generated a great deal of discussion among the States. Specifically, the States challenged the validity of the answers. As an example, the SSAs in New Mexico and Utah do not license or certify any places, yet over 50 percent of non-approved facilities in New Mexico and over 80 percent in Utah claimed that they were approved by an SSA.

Several States voiced concern about the term "State approved," contending that the term implies some official State authorization. However, State practices vary so much that it makes it difficult to develop a single criterion for determining approved facilities for the Directory. The States attending the meeting illustrated this variability in their administrative practices in their discussion of SSAs that license and ones that do not license or certify. OAS would like States to "approve for the directory" all legitimate substance abuse facilities. The States urged OAS to improve the description of what States should consider when designating places as approved for the directory, and to include the description in the Guidelines for DASIS State Contacts.

Utah mentioned that having a recent N-SSATS file is very important for them because the State requires substance abuse facilities to answer the N-SSATS in order to have a license. Synectics and MPR will work out a system to have I-SATS updated on a monthly basis with the N-SSATS status.

Mini-N-SSATS

Having the Locator in addition to the Directory has made collecting information on new facilities between administrations of the N-SSATS more critical. To meet this demand, the Mini-N-SSATS—consisting of only the survey questions that relate to the Directory—has been instituted. The Mini-N-SSATS will be administered monthly.

State Presentations

Arizona

Glen Tinker gave a presentation on how Arizona validates its State data to comply with the TEDS requirements. The Arizona Department of Health Services first submitted data about 18 months ago. At the beginning the error reports from Synectics showed many errors due to the fact that data submitted to the State from the behavioral health authorities was not validated. An example is the requirement for consistency between DOB and age at first use. In Arizona's validation program, they use the Synectics source code to generate age in the same way. If there is a discrepancy, the program gives it an unknown code. Other items validated are pregnancy status and sex. For the DSM diagnosis, Arizona has thousands of diagnosis codes. In order to have them comply with the TEDS format the decimal point is removed, the codes are tested to see if they are valid, and then the decimal point is replaced.

This presentation was followed by questions and comments about the error reports. The States suggested that the error reports include more explanations to make them more understandable, especially for new personnel. It was also suggested that, although this information is in the TEDS manual, it would be helpful to put it on the web page.

Colorado

Nancy Brace gave an overview of the Colorado system, which is in the process of changing. They have been using equipment and software that is 23 years old and not supported by anyone. There is little or no documentation. They used to have seven data staff, but now have two. Two of the seven have moved to ITS. Colorado went from a fee-for-service system to a managed care system. In three months the system went from concept to implementation. The request for a new $1.5 million data system was submitted twice to the State and was turned down twice. So last year a less ambitious request was submitted, one that would migrate DACODES (the TEDS data) off the mainframe to a server environment, and it passed. They now have one year's funding of $300,000 to do this. In the process, they have set up an edit program to be used at the provider site level. They have looked at an admission/discharge matching system. The mainframe was rigid on matches; for example, "Suzie" and "Suzy" would not match. They do not do discharges now, but they will shortly. Providers are paid

based on admission submissions, and Colorado is looking at paying on discharge submissions also. In Colorado, providers are grossly underpaid and tough to get, so they cannot be punitive, although they need good data. They are revising the data instrument (a committee is looking at capturing "need treatment" and "want treatment"). TEDS items are the baseline for the instrument.

Ms. Brace asked if any of the States attending the meeting had a true episode-based system. Oklahoma indicated that they did. Utah stated that they had to manipulate the system to achieve an episode system. Colorado stated that their system was a modality-based system and that they had particular problems when clients moved from one managed care system to another. New Mexico said that they have moved away from the words "admit" and "discharge." They use registration and levels of care. Throughout registration, a client will move within levels of care. The record is never closed until the client leaves.

[Dr. Goldstone mentioned that the new SAMHSA reauthorization has a provision for funding State infrastructure development. There is some conflict in the agency over its priority, but it is designed to help subsidize building or improving State administrative systems. However, everyone recognizes that States, with pressure to use funds to provide services, are not likely to give priority to their systems. The agency needs to understand that for some States, support of this nature is critical. State substance abuse directors often have other priorities. There is interest in the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to promote this issue with State Directors.]

Louisiana

Juanita Alexander presented an update of the Louisiana system. In 1999, the MIS developed a mission statement that data they collect should be accurate and timely. As part of the program they will disseminate reports, and institute measures for quality control. There are 10 regional offices, and there has been a problem in getting the regional offices to buy in. At first Louisiana tried to get partnerships. Now they are doing performance-based budgeting. The regions need to realize that information sent or not sent has an impact on their programs staying open.

Louisiana had an N-SSATS response rate of over 95 percent. One of the reasons for high participation was the improved participation from private facilities that want to be in the Directory. Their office actively pushed the survey emphasizing that facilities had to do the survey to be recognized. Ms. Alexander also emphasized the importance of letters to the facilities from the State Directors. Their office gets many calls from facilities asking about the legitimacy of the survey. She also commented on the importance of being able to review the data.

Louisiana is an active user of I-SATS On-line and intends to use the input in their Directory of Services. Louisiana does monthly updates.

Louisiana submits TEDS data electronically instead of via tapes, although they still have a mainframe system. Ms. Alexander said they found the submission error report hard to figure out. A common error was submitting changes to records as admissions instead of as changes. Louisiana uses TEDS data all the time.

A web-based system is in development. The system being implemented is something like New Mexico's, which will have admission, discharge, and status change dates. They are looking for an integrated system including accounts receivable, contracts management, etc., many of which are already on-line. One of the problems has been that the State facilities have software and hardware but the

contract facilities do not. Louisiana is interested in talking to other States that have done or are doing this. Plans call for the incorporating the HIPAA regulations when they are standard.

New Mexico

Carol Thomas started by describing the State organization for substance abuse. The Department of Health has mental health and substance abuse non-Medicaid clients. The Department of Human Services handles the Medicaid population, but the Department of Health does provide services to Medicaid clients (non-Medicaid reimbursable services). There were separate mental health and substance abuse divisions, but they were brought together a few years ago. They had two separate information systems, and over the past few years they have had to integrate the data into one system. Two years ago an RFP was released for a commercial off-the-shelf system. They have three components from a Pennsylvania company: an Internet product; a managed care software product; and a reporting warehouse. All systems are on a SQL7 server. At the same time, they are changing the way they do business. New Mexico used to be a fee-for-service system, but is moving to a regional care basis. There are five regions. Last year, they initiated a regional care coordination plan. They have contracted with coordinators. They also have fee-for-service Native American services. All these services upload data electronically via the Internet product monthly. The managed care software is used to move the data to the warehouse. They moved to performance-based budgeting this year, so reporting is more important.

For the substance abuse Block Grant waiting list requirements, they have to deal with the waiting list and capacity management requirements. The waiting list data are collected during the registration process. New Mexico will use a secure web site to have agencies report weekly on their capacity. Care coordinators (CCs) and providers have to use digital certificate to log in to upload or download data. State facilities in the network have a different login than the CCs. They have incorporated capacity management changes into the web site. Users start with the "Provider connect" function to see if the client is already registered in order to coordinate care. For capacity management of priority clients, facilities enter and update capacity on a weekly basis. The capacity information includes total slots, empty slots, and comments. This information is used to assist places at 100 percent capacity to find other suitable places for client placement.

Several questions were asked about capacity and the difficulty in measuring capacity particularly for outpatient services. There is a great deal of interest in capacity, and this information is requested as part of the block grant.

Oklahoma

Mark Reynolds showed performance indicators data. Oklahoma has a combined Department of Mental Health and Substance Abuse Services. It also handles sexual assault. The current system is web-based and has been operating for about one year. Facilities only have to report clients for which Oklahoma pays part or all of the care. For each agency, they have different indicators by level of care and case mix (from a logistic regression model). For each indicator there is a chart comparing the agencies against one another. Oklahoma is one of a few States that has interagency data sharing. Oklahoma has data from several agencies and the data includes corrections data and mortality data. The data are matched using an algorithm based on probability of a match using name, SSN, and DOB. Currently the combined dataset is based on only the matched cases. The reports are available on Oklahoma's web site (www.odmhsas.org/specialreports.htm).

Utah reported that they are beginning to do matching studies, and Colorado said they do it for special studies using name and DOB, but not SSN.

Oklahoma spent 6-12 months with lawyers working out data sharing problems and client confidentiality. Oklahoma volunteered their help, including the forms and agreements they used, to any States interested.

Texas

Jane Maxwell reported for Texas. Texas began CODAP reporting in 1973 in drug agencies. Alcohol agencies were added in 1983, and alcohol and drugs were merged in 1988. The current system is web-based, and providers are required to submit an admission form prior to payment.

A new, greatly expanded system is in the process of being implemented. There are separate adult and youth forms. In addition to collecting admission data, discharge and 60 days post-discharge data are being collected. Ms. Maxwell presented prevalence data on cigarette smoking, heavy alcohol use, marijuana and cocaine use, and drug dependence in Texas and with U.S. comparisons. The Texas treatment trends and patterns track very closely with national TEDS data and data from the National Household Survey on Drug Abuse (NHSDA).

Utah

Patrick Fleming reported that Utah is actively building a web-based system. The system is geared to get data for the block grant. Utah has local substance abuse agencies in 13 sub-state regions. There is a funding formula that allocates dollars to areas; they have no fee-for-service. Each region runs its own data system. They're using the "I-15" model; that is, design and build in a continuous process. They started with the prevention system, which is a web-based data collection (it was an Excel database). Plans are to collect pre- and post-test data, client rosters, etc. for reporting on the Block Grant. Under development is a web-based system where client data will be drawn from TEDS and automatically added to the year-end forms. A self-administered ASI will be available on the PC. Every client entering treatment will complete the ASI and it will be immediately available at the State level. The information can be downloaded and it will be used by the local provider for patient treatment and placement. This information will also be available at the State level. Aggregate reports can be automatically generated by providers.

Each of the 13 areas has its own system for collecting the TEDS data. Each area does comply with the standard TEDS file format. Unfortunately money is very tight, and they cannot afford to make changes to the TEDS system. Utah would like a client-based statewide web system that can be integrated with the accounting systems and treatment planning software. However, funding is not available.

Using Data from the Treatment Episode Data Set (TEDS)

Dr. Leigh Henderson of Synectics gave a slide presentation demonstrating some of the uses of TEDS data at the national level. These featured U.S. trend maps for 1992–1998 for heroin, amphetamines, and marijuana admissions. Also featured were density plots of age versus duration of use for first-time admissions to treatment for injected and inhaled heroin.

To introduce issues surrounding TEDS quality control, she diagrammed the relationships among the I-SATS, TEDS, and N-SSATS, and how these have changed over time. When the TEDS system was originally conceived, all data for the I-SATS, TEDS, and N-SSATS were received from the States. There was a requirement that both TEDS and N-SSATS be reported at the same level. This made it

possible, based on the relationship between TEDS admissions and the N-SSATS census, to estimate the number of admissions in facilities that were not required to report TEDS data. However, the steps taken to ensure a more complete inventory—centralized administration of the N-SSATS, extensive efforts to identify facility networks and enumerate sites, and the I-SATS augmentation efforts—have meant that the connection between TEDS and N-SSATS is no longer clearly defined. States were asked if they could recommend ways to identify "networks" of facilities reporting TEDS data, and to indicate these on the I-SATS.

Using Data from the Office of Applied Studies (OAS)

Dr. Goldstone gave a presentation on the data OAS collects and the uses of the data for policy. The data collected are required by section 505(c) of the Public Health Service Act. The law requires the annual collection of data on medical problems caused by and deaths due to drugs. OAS collects this data in DAWN. The data are collected from hospital emergency rooms and from Medical Examiners and Coroners. Currently the system is being revised to get it closer to the intent of the statute.

The law also requires SAMHSA to describe the number of public and private facilities. OAS does a reasonable job on public facilities, but coverage is much poorer on clients in private facilities. He would like to see SAMHSA require States under the Block Grant to collect and send this information to OAS. Although States have no control over any private facility with no public money, if any Federal money is used, States are covered by these statutes. Having a complete statistical picture of all clients and facilities regardless of ownership is necessary for good program planning. The source for this information is N-SSATS.

It is very important to SAMHSA to have annual costs by modality. In the past OAS tried to get costs or revenue data, but that did not work very well, partly because the business office did not answer that part of the questionnaire. OAS has sponsored a separate special survey (ADSS) to collect cost data. Using data from ADSS and adjusted to 2001, the average cost is $2,087 per case. That includes residential, methadone, and outpatient care, but excludes hospital. It was done using accounting techniques and probably is the best estimate the agency has ever had. It is also important to have data on personnel by type and number. Plans call for adding these to the cost survey, and conducting it every other year, starting perhaps in 2003. The cost survey will be a sample survey.

The law also requests that SAMHSA collect information on the number of admissions, characteristics of admissions, and readmissions. The law talks about prior treatment and the nature of that treatment. Dr. Goldstone presumed the law meant that if people had to be readmitted, something was wrong with their last treatment process. He does not think OAS will be able to collect this.

TEDS data collect source of payment. It is reported for publicly funded clients, but often missing for private clients, so we miss much of the private insurance market. Currently there is a great deal of interest in treatment completion time. This can come from the discharge data that OAS is currently encouraging States to report. The TEDS data system is the source of these data, but a lot of data necessary for policy is missing.

Requirements for incidence and prevalence data are fulfilled by NHSDA. OAS is supposed to have small area estimates of incidence and prevalence (municipalities, by law).

Utah asked if the household survey could be a composite of State data so that the estimates would be more comparable to the State data. This lack of comparability has caused difficulty in the States and

requires them to explain the differences. Unfortunately it is not feasible to make the national survey comparable because of all the State differences. OAS must do everything it can to standardize data collection. Decentralizing decisions and data collection moves away from that. OAS does as suggested for TEDS because it has some rules about minimum data. This is why OAS has centralized the data collection for the N-SSATS—the data are much more comparable. It is very difficult to design a questionnaire that will recognize all the State differences.

What if the questionnaire remained the same but each State came up with interviewers and coordinators? The contractor could train them and the State would be responsible for operations. Editing would be done by the contractor. This can work; an example in the past was National Ambulatory Care Survey (a survey of admissions to hospitals), where three States contracted directly with the OAS contractor. The sample was drawn nationally and the same forms were used in the States. There have been several internal discussions about State participation but logistically it has many problems. Right now OAS is having a great deal of difficulty keeping up with the current workload. However, State participation may be possible in the future.

In the meantime, it is important to compare the results among surveys to see if the differences are plausible. As an example, the Federal government funds YRBS, MTF, and NHSDA. All of these collect marijuana data. The levels of the estimates from the surveys are different, but the trends are the same.

Another area mentioned in the Public Health Service Act is information on emerging problems. One source is DAWN data on youth. At the time marijuana emerged, it was seen not only in treatment but also in emergency room visits. This emphasizes that marijuana is not so innocuous. This information helped in the push for the 1996–97 youth marijuana initiative.

Recently there has been a lot of publicity about club drugs. The Federal government had no picture of this until it was produced from DAWN 6–8 months ago. There was a growing sense of a problem, but no numbers at the national level to confirm that there was a problem. OAS cannot do these estimates in the NHSDA because the drugs are still rare. But the DAWN data were widely distributed in the government and elsewhere, and the December 2000 *DAWN Report* on Club Drugs has been the basis of many grant applications.

Using TEDS data OAS has displayed treatment data by drugs in a series of maps that showed the geographic spread over time. The amphetamine maps—which displayed the beginnings of a serious problem—were shown to the Secretary. The Office of the National Drug Control and Policy saw these data and they made a tremendous impact. Not only did the maps describe the nature of a problem sweeping across the country, but this was use of data in a way they had never seen; that is, not describing populations, but showing the nature of the problem as it was emerging.

Data from NHSDA on illicit drug use by age shows an aging cohort of heavy users. This group will probably remain heavier users than comparable earlier cohorts of same age. The agency is now focusing on 18- to 25-year-olds. Without these data, the agency would have remained focused on teens.

A correlation analysis of per capita Block Grant spending and past year dependence on alcohol and drugs shows very little correlation. The Block Grant formula should ensure that there is an equal chance of getting care in State X as in State Y. But the Block Grant distribution has nothing to do with the level of problems across States. If the government is putting out targeted expansion of capacity grants and

extra Block Grant money and other service grants, there is an opportunity to make sure these grants go to places of higher prevalence. Dr. Goldstone predicted that this is how data on prevalence will be used in the next couple of years. Although the levels of prevalence may not be totally accurate, the fact that the same technique is used in the same way year after year makes the changes observed from the baseline quite accurate.

The NHSDA questionnaire was redesigned to estimate treatment and need among States. In 1998, treatment level 1 and treatment level 2 were asked. These designations were replaced with questions based on the DSM-IV. The questions cover physiologic problems and behavioral problems, and an algorithm determines abuse and dependence. Questions were also added on treatment. The results were published in last year's NHSDA report.

DASIS Reports

A new report series was introduced at the meeting. These are short reports focused on a single topic and will cover the following datasets: DAWN, N-SSATS, NHSDA, and TEDS. The reports are color coded for each dataset and will come out once a week. There are 18 to 24 in queue.

The reports will be on the web, with a link from the OAS web page. OAS is interested in receiving topic suggestions from the States. Participants at the meeting suggested that the reports be indexed.

Demonstration of Online Data Analysis System

The Substance Abuse and Mental Health Data Archive (SAMHDA) goal is to provide researchers, academics, policymakers, service providers, and others with ready access to substance abuse and mental health data. Data and documentation can be downloaded from the Internet (http://www.icpsr.umich.edu/SAMHDA/index.html). Datasets are in SAS and SPSS format, and documentation is in PDF format.

The system uses a Data Analysis System (DAS) developed by the University of California at Berkeley. DAS was developed specifically for use on the Internet. It computes frequencies, cross tabulations, means, and correlations, and permits construction of subsets. Customized datasets and codebooks can be downloaded. The documentation includes a title page, codebook notes, weighting information, bibliographic citation(s) and data disclaimer, and descriptions of imputations, data anomalies, and data problems.

Among the datasets available are TEDS and NHSDA, and data from DAWN.

The demonstration focused on the TEDS data. The system allows the user to generate a query and build a table to answer the query on-line. In order to protect confidentiality, the TEDS data undergoes a disclosure analysis. However, unlike the past public use file, this file includes the complete file rather than a one in four sample of the original file. Other recent changes include color-coding cells in cross tabs to indicate statistical significance. Other statistical analysis improvements include the addition of multiple regressions and comparisons of correlations.

Only two attendees at the meeting had heard of the system. The general feeling was that there needed to be more publicity. In general, e-mails have been an effective way to communicate with the States. Two projects in the works that may help are a self-instruction tutorial and a simplified codebook. Experience shows that people find the system very useful once they get familiar with it.

Health Insurance Portability and Accountability Act (HIPPA)
When HIPAA began to get attention 18 months ago, OAS began to get calls from SSAs about how it would affect them. There were particular concerns that maybe they would not be able to share data as before. There was lots of confusion and little understanding or knowledge about the act.

The purpose of the Act is to improve the efficiency and effectiveness of the health care system by establishing standards for the electronic exchange of certain administrative and financial transactions and to ensure the security and privacy of health information. The Act applies to all health plans, all health care clearinghouses, and all health care providers that elect to conduct transactions electronically. HIPAA has three major elements: transactions and code sets; identifiers; and security and privacy protections.

The first element is the transaction code set standards. HIPAA requires the adoption of national standards for efficient electronic administrative and financial transactions. The proposed rule for transaction and code set standards was published May 7, 1998, and the final rule was published August 17, 2000. The compliance date was set for October 16, 2002 (October 16, 2003, for small health plans).

The second element concerns identifier standards. HIPAA requires the adoption of standard identifiers and an assignment of a National Provider Identifier (NPI) for health care providers, employers, health plans, and individuals. The proposed NPI will be assigned to every health care provider (individuals and facilities); it will be a lifetime number, have no embedded intelligence, and will replace the multitude of identifiers currently assigned by health plans.

The third element is the Health Information Security and Privacy Standards. HIPAA requires the adoption of security standards to protect health information. The proposed security standards should be flexible; have technology-neutral guidelines and policies; have reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of information, protect against threats or hazards, and prevent unauthorized uses or disclosures; and employ a digital signature standard.

The privacy standards apply to individually identifiable health information held or disclosed by a covered entity in any form (electronic or paper). Covered entities are health plans, health care clearinghouses, and health care providers that transmit any health information in electronic form in connection with an HIPAA transaction. The standards also cover contractors and agents of covered entities. A covered entity may use or disclose protected health information for research provided that an Institutional Review Board (IRB) or privacy board approves a waiver of individual authorization and the decision is consistent with waiver criteria.

Information can be used for research, provided that the personal identifiers have been removed so that the remaining information cannot be used alone or in combination to identify an individual. In general, dates of birth and/or of specific health events are not permitted. An alternative solution is to have a disclosure analysis done by a person with knowledge of and experience with appropriate statistical methodology.

Redesign of the Drug Abuse Warning Network (DAWN)

The DAWN data collection system is in the midst of an evaluation and subsequent redesign. The system will focus on monitoring patterns of drug use, tracking drug-related illness, and detecting new drugs. Talking to the users of the information was part of the evaluation. Currently the system is made up of a representative sample of short-term, non-federal general hospitals and a non-representative group of medical examiners that represent 139 jurisdictions and 40 metropolitan areas.

The strategy that emerged from the review was to replace the paper system with a web-based data entry system and provide even more timely feedback. Currently, 57 medical examiners are reporting in the new system. A system for emergency rooms will begin beta testing in May. Other changes were to simplify case selection, expand case definition, and include additional data elements on drug abuse, adverse events, presenting problems, and disposition.

The sample of emergency rooms will be expanded to provide more precise material estimates and expand the number of metro area estimates.

Closing Remarks

Dr. Goldstone ended the meeting by thanking the participants for their participation and urging them to feel free to contact OAS staff with any suggestions or problems they may have. He reiterated that the feedback OAS receives proves very useful and hoped that the State representatives find the exchange equally beneficial. Dr. Goldstone reiterated the importance of the partnership with the States and how important they are to the proper operation of the DASIS system.

AGENDA
DASIS REGIONAL MEETING

Arizona, Colorado, Louisiana, New Mexico, Oklahoma, Texas & Utah
July 17-18, 2001
Salt Lake City, Utah

Tuesday

8:30 a.m.	Continental Breakfast
9:00 a.m.	Welcome and Introduction ..... *Donald Goldstone, OAS*
9:15 a.m.	Inventory of Substance Abuse Treatment Services (I-SATS) • Demonstration of Treatment Facility Locator ..... *Deborah Trunzo, OAS* • Demonstration of I-SATS Quick Retrieval ..... *Jim Delozier, Synectics* • Discussion of State practices
10:00 a.m.	National Survey of Substance Abuse Treatment Services .... *Geri Mooney & Barbara Rogers, MPR* • Outcomes of 2000 N-SSATS • Mini N-SSATS • Schedule for 2002
10:30 a.m.	BREAK
10:45 a.m.	State Presentations ..... *State participants – AZ, CO, LA, NM*
12:00 p.m.	LUNCH
1:00 p.m.	State Presentations (continued) ..... *State participants – OK, TX, UT*
2:00 p.m.	TEDS, the NHSDA and the use of Data • The role of TEDS ..... *Donald Goldstone, OAS* • Using data from TEDS ..... *Leigh Henderson, Synectics*
3:00 p.m.	BREAK
3:15 p.m.	TEDS, the NHSDA and the use of Data (continued) • Evaluating the TEDS Process ..... *Peter Hurley/Jim Delozier, Synectics* • Race categories in TEDS ..... *Jim Delozier, Synectics* • Federal Use of Data from the NHSDA ..... *Donald Goldstone, OAS*
4:30 p.m.	Adjourn

Wednesday

8:30 a.m.	Continental Breakfast
9:00 a.m.	Demonstration of the SAMHDA On-Line Data Analysis System ..... *Charlene Lewis, OAS*
9:30 a.m.	Health Insurance Portability and Accountability Act (HIPAA) ..... *Judy Ball, OAS* • Transactions • Identifiers • Privacy • Security
10:30 a.m.	BREAK
10:45 a.m.	HIPAA (continued) ..... *Judy Ball, OAS*

11:15 a.m.	The “New DAWN”	*Judy Ball, OAS*
11:45 a.m.	Wrap up	*Donald Goldstone, OAS*
12:15 p.m.	Adjourn	

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Salt Lake City, Utah
July 17 & 18, 2001

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